Recovery and Homeless Services: New Directions for the Field

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Abstract: The recovery movement is reshaping approaches to treatment of mental illness, substance abuse, and traumatic stress disorders. Yet recovery principles have not been well integrated into the homeless assistance network, despite high prevalence of mental illness, substance abuse, and trauma histories among people who are chronically homeless in the United States. We review approaches to recovery and recovery-oriented care and propose recommendations for adopting recovery oriented care within the homeless assistance network.

Keywords: Recovery, recovery-oriented care, homelessness, homeless services.

INTRODUCTION

Over the past two decades, the concept and principles of recovery have gained acceptance in the areas of mental health, substance use, and traumatic stress treatment as they have demonstrated improved outcomes. Multidisciplinary research in the behavioral health fields demonstrates that people can and do recover from mental illness, substance use disorders, and traumatic stress disorders [1-3] with and without traditional intervention [4]. In the United States, many people experiencing homelessness also suffer from co-occurring mental illness, substance use, and traumatic stress disorders, and could benefit significantly from programs employing a recovery-oriented approach.

However, a review of the literature shows little evidence that recovery principles have been systematically integrated across the homelessness assistance network.[1] While individual programs and providers may be providing care that integrates recovery principles, there is little evidence that homeless services have embraced the recovery movement to the same degree as the broader behavioral health fields. Homelessness assistance programs involve a diverse array of housing, emergency shelter, food service, employment assistance, medical care, mental health, addictions, and social services programs. Constructing a unified, recovery-oriented model of care across this multidisciplinary network of providers—often separated by different federal funding streams—poses unique challenges.

This paper argues that given the population it serves, the homeless assistance network must consider a system-wide adoption of a recovery orientation. It reviews the emergence of the concept of recovery and recovery-oriented care across the areas of mental health, addictions, and traumatic stress. It then turns to a discussion of the challenges of operationalizing a recovery-oriented approach to homeless services and systems, drawing from lessons from mental health and addiction services. We identify the need for a shift in the service delivery model and the need for an increased role for consumers as "recovery ambassadors" [5] and for consumer integration at all levels. Lastly, we discuss lessons learned from implementation of recovery-oriented mental health and addiction treatment programs in the state of Connecticut, and the challenge of translating recovery principles into standards and objective practices that can be observed and measured. The paper concludes with a discussion of the adoption of recovery principles across the homelessness assistance network, and the implications for research, practice, and policy.

DEFINING RECOVERY

With the 2001 publication of "Transforming Mental Health Care in America," the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) took a leadership role in identifying recovery as the "single most important goal" for the mental health service delivery system [6]. The President's New Freedom Commission on Mental Health 2003 report defines recovery as "the process in which people are able to live, work, learn, and participate fully in their communities" [7].

In 2004, a SAMHSA expert panel issued a consensus statement on recovery, establishing ten fundamental components that define mental health recovery. According to the SAMHSA consensus statement, recovery must be self-directed, individualized, person-centered, holistic, and encompass every aspect of an individual's life. Empowerment of the individual in recovery is a fundamental cornerstone of recovery. The SAMHSA consensus statement emphasizes that recovery is non-linear, must be strengths-based, and needs to build upon the multiple abilities of the individual. Peer support is recognized to play an important role in fostering recovery and developing supportive relationships. Respect and personal responsibility are fundamental values of recovery, and hope is the overriding message and catalyst of the recovery process [8]. Anthony identifies recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or

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[1]There is increasing recognition that collaboration between multiple agencies, programs, and providers is necessary to address the problem of homelessness. These collaborations form a larger homeless assistance network [12].

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roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" [9].

The definition of recovery varies across fields and contexts, but at base it is defined as a process through which an individual regains control of major life decisions and is able to function in significant and valued roles [10, 11]. For people with mental health issues, recovery is understood as a restoration to an optimal level of functioning within the limitations of one's impairment, or else as full recovery. In the addictions field, recovery refers to the process of achieving and maintaining abstinence from substance use. People with substance use problems who are abstinent are considered "in recovery," a life-long process. For those diagnosed with traumatic stress disorders, recovery is viewed as the process of regaining a sense of safety, control, connection, and meaning that was lost or damaged by trauma.

Recovery-oriented care is premised upon the belief that recovery is possible for everyone and that no one is beyond hope [12]. As part of the recovery process, individuals learn to accept, and eventually embrace, their own limitations and are able to identify the supports they need to mitigate symptoms. Acceptance leads to empowerment, choice, self-determination, and community integration. For individuals with mental health issues, substance use problems, or trauma histories, the recovery process is fostered by learning to integrate symptom management into daily life and to mobilize the support needed to increase their likelihood of success.

THE NEED FOR RECOVERY-ORIENTED CARE FOR PEOPLE EXPERIENCING HOMELESSNESS

People experiencing homelessness are living with a multitude of losses, including the loss of a home, employment, economic security, family, health, and personal security. People who are homeless have lost the protection of home and community, and are marginalized and stigmatized within the larger society. Once homeless, a person loses the right to privacy, safety, reassuring routines, a place to keep personal belongings, and connections to community. People who are homeless experience disruptions in attachments and relationships with others including family members, friends, pets, and neighbors. Excluded from society, people experiencing homelessness live in abject poverty.

Observing that "life on the streets can come close to causing a civil death, in which people cease to be fully social human beings," the anthropologist Richard Desjarlais argues that being homelessness constitutes a loss of personhood, which he defines as the state of being a socially recognized and engaged human being, acknowledged by law as the subject of rights and duties and the bearer of faculties of communication, reason, and moral judgment [13]. In cities, street dwellers tend to be viewed as shadowy untouchables living on the margins of society. Labeled as vagrants, drunks, or crazy, people without homes are described in the aggregate as "the homeless," nameless and faceless. For people experiencing homelessness, this creates the sense of being a ghostly nonperson, absent and silent in the world of others.

The homeless population is highly heterogeneous, and is furthermore crosscut by mental illness, substance use, and/or co-occurring conditions, and traumatic stress disorders. The 2007 US Conference of Mayors "Hunger and Homelessness Survey," of 23 cities found that 22.4 percent of people who are homeless surveyed have a mental illness. Among adults using homeless services, 31 percent reported a combination of mental health and substance use problems (alcohol and/or drugs). According to the 2007 survey, approximately 37.1 percent of homeless individuals are dealing substance abuse issues [14].

In addition to these conditions, many people experiencing homelessness are suffering from traumatic disorders. Researchers argue that the experience of homelessness is traumatic and that homelessness is a risk factor for emotional disorder [15]. Homeless women and veterans, in particular, tend to have significant trauma histories. In one study, 92 percent of homeless women studied reported experiencing severe physical and sexual assault and 25 percent reported experiencing random violence during their lifetime. Sixty-six percent of the homeless women reported severe physical violence during their childhood and 43 percent were sexually abused before the age of 12 years old [16]. For children, homelessness has been found to be experienced as a traumatic event, and roughly one-fifth of homeless children experience separation from their immediate family [17].

RECOVERY IN CROSS-DISCIPLINARY PERSPECTIVE

In this section, we examine cross-disciplinary perspectives on recovery across mental health, co-occurring conditions, addictions, and trauma as a first step toward establishing the need to integrate these perspectives into programs serving people who are homeless. Given the high prevalence of mental illness, substance use, and trauma histories among people who are homeless and the promising outcomes of recovery-based approaches, the adaptation of a recovery-orientation could offer a unifying vision for systems of care within the homeless assistance network.

PERSPECTIVES ON RECOVERY IN MENTAL HEALTH

The recovery paradigm in mental health argues that recovery is not simply an absence of symptoms, but a process of reclaiming a satisfying life even within the limitations of a mental illness. A review of the literature on mental health recovery identifies a broad range of elements associated with recovery, including person-centered values, hope, increased agency, self-determination, meaning, purpose, awareness, and potentiality [18].

Consumers[2] and their advocates propelled the recovery movement by calling for greater choice, self-sufficiency, self-management, and consumer-centered care focused on recovery [19]. First person narrative accounts by consumers called for collaborative treatments and helped to put

[2] A consumer is defined as a person with the lived experience of homelessness, mental health issues, substance use issues, and/or traumatic stress.

recovery on the mental health policy agenda [19-21]. Pioneering longitudinal research in Vermont and Maine demonstrated improved outcomes for mental health patients and added credibility to calls for recovery as increased knowledge about the course and outcome of mental illness grew [22].

These changes led to shifts from despairing prognoses to a belief in the possibility for better outcomes for individuals with schizophrenia and other major mental illnesses [1]. As people became more hopeful, mental health treatment goals began to shift from stabilization and maintenance to greater support for recovery-oriented care for all [3]. Some consumer advocates take issue with the stigma attached to the label of permanent mental impairment and propose an empowerment framework based on the belief that full recovery is possible for everyone [20]. Recovery is a "philosophy of hope" for people with mental health issues and their support networks [23]. Consumers emphasize the importance of holding onto hope, taking responsibility for one's own wellness, self-education, self-advocacy, peer support, and mutual support within clinical settings [21].

Consumers and their advocates worked to expand the scope of recovery definitions to include the outcome of being able to function and cope well even while symptomatic. Recovery is understood to be the process of gaining greater control over and minimizing the impact of symptoms. The consumer movement rejects the notion that consumers must be symptom free in order to enjoy full community participation and citizenship rights. Many providers and consumers now believe that consumers can experience positive outcomes associated with increased functioning, greater satisfaction, and experience a diminished negative impact of mental health issues on their lives.

PERSPECTIVES ON RECOVERY FROM SUBSTANCE USE

Beginning in the early 1940s, Alcoholics Anonymous (AA) was the first modern movement to pioneer recovery from addiction to alcohol as an approach and process. The Alcoholics Anonymous model views recovery as a process of achieving and maintaining a consistent state of abstinence from alcohol use [24]. The achievement of abstinence is a prerequisite for being in a state of recovery, but this may not mean that a person is "cured." In treatment for addictions, recovery is defined as gaining information, increasing self-awareness, developing skills for sober living, and following a program of change [25]. Role models and relationships are key supports for individuals in recovery. A review of the research on psychosocial modalities of treatment of addictive disorders suggests that the most effective treatments help clients shape and adapt to their life circumstances by focusing on their community contexts and developing social and life skills that increase competence in coping with daily life [26].

In the substance use recovery model, relapse, or the return to active substance use is an anticipated event in the course of recovery, and harm reduction strategies are encouraged to mitigate the dangers and health risks of continued substance use.[3] The recovery model uses Motivational Interviewing and the Transtheoretical Model of Change to promote decreased substance use while the individual moves through the recovery process. Research shows that Motivational Interviewing, a counseling style that helps individuals explore and resolve ambivalence about change, increases participation in substance use treatment programs, and leads to positive treatment outcomes [27]. Motivational Interviewing is an empathic, person-centered counseling approach that prepares people for change by helping them resolve ambivalence, enhance intrinsic motivation, and build confidence to change [28]. Likewise, the Transtheoretical Model of Change, known colloquially as the "stages of change," is a model for intentional behavior change based on the idea that people must progress through five distinct stages to achieve lasting change [29, 30]. Both Motivational Interviewing and the stages of change model seek to foster recovery by helping consumers think differently about their behavior and to consider what might be gained through change and recovery.

RECOVERY AND CO-OCCURRING CONDITIONS

It is estimated that 50 to 75 percent of individuals in treatment for addictions also have co-occurring mental health issues [31]. The two conditions adversely affect each other [32], and research supports the effectiveness of integrated and coordinated treatment for both conditions provided in tandem by the same clinician or team of clinicians in a single setting [26, 33]. However, most treatment settings are unprepared to effectively manage integrated treatment of co-occurring substance use and mental health issues [34] and further research is needed to determine best practices for treatment of individuals with co-occurring addictions and serious mental illnesses [26]. A major challenge to the integration of treatment is different clinical perspectives of providers and clinicians in the mental health and addictions treatment field [35], and the limitations of the "acute care" model of treatment [11].

However, emerging research suggests that integrated treatment services with a recovery-orientation produce better outcomes than services focused solely on symptom reduction. In one recent study, researchers observed that among people who have experienced substance use problems, serious mental health issues, and homelessness, "progress in mental health recovery appeared dependent more on gaining control over substance use, avoiding negative social ties, and attaining independent housing than on achieving psychiatric symptom reduction," while also noting the complexity of recovery for dually diagnosed homeless persons [36]. By gaining the stability of independent housing and control over substance use, an individual who is homeless is able to concomitantly make significant progress in the process of mental health recovery. Furthermore, a common vision of recovery can provide a new framework to organize services to better support and care for the long term and complex needs of individuals with co-occurring conditions [11].

[3] It is important to note that the recovery model differs from the abstinence model, which does not espouse harm reduction strategies.

PERSPECTIVES ON RECOVERY FROM TRAUMATIC STRESS: TRAUMA-INFORMED CARE

The experience of trauma is defined as an overwhelming, often unpredictable event that leads to feelings of powerlessness, extreme vulnerability, terror, lack of safety, and loss of control [37-39]. Interpersonal violence may compromise the ability to form trusting relationships since the traumatic event may have occurred at critical developmental junctures and involve family members or close friends. The experience of trauma is unique to each individual, as one person may experience an event as traumatic, while another person may not. In order to create strategies for fostering recovery, providers must understand the behaviors and symptoms manifested by traumatized individuals as adaptations to prior threats.

Traumatic stress shapes a person's belief system, feelings, and self-perception and may lead to various post trauma responses that are expressed physically, emotionally, interpersonally, and cognitively [37]. Part of the work of recovery is to understand, "detoxify," and integrate various aspects of the traumatic experience.

In trauma-informed care, recovery is defined as the process through which an individual develops a more integrated sense of self, a greater capacity for developing mutually supportive relationships, a sense of control over one's body, a increased capacity for safety and self-soothing, and better coping skills for managing symptoms and distress related to the traumatic experience [40]. Recovery from trauma is a long-term, highly individualized process that often takes a lifetime. This process often involves identifying the experience as traumatic; understanding the range of post trauma responses; learning about the nature of intrusive memories, avoidance, and hyper-vigilance; identifying specific triggers; developing strategies to manage triggers; and reconstructing the traumatic event. As trauma survivors actively work through the traumatic experience to mitigate its intrusion into daily life, recovery means they live, work and function as best they can, even while dealing with unpredictable emotional, psychological and behavioral trauma content intruding into the present.

Trauma-informed services integrate recovery principles in the treatment of individuals suffering from traumatic stress [38]. Harris and Fallot [41] conceptualized the notion of trauma-informed services for survivors of violent victimization. Elliott, Bjelajac, Fallot *et al*. [40] elaborated on their approach by articulating ten principles for designing trauma informed services, with a particular focus on survivors who have co-occurring substance use or mental health problems. The ten principles of trauma-informed services include:

- Recognize the impact of violence and victimization on development and coping strategies
- Identify recovery from trauma as a primary goal
- Employ an empowerment model
- Strive to maximize consumer choices and control over their recovery
- Embed services in a relational collaboration
- Create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance
- Emphasize a person's strengths, highlighting adaptations over symptoms and resilience over pathology
- Minimize the possibilities of retraumatization
- Strive to be culturally competent and to understand each person in the context of their life experiences and cultural background
- Solicit consumer input and involve consumers in designing and evaluating services

Trauma-informed care incorporates recovery principles to emphasize the importance of creating safe environments in which boundaries are clear, power is shared, consumer choice is ensured, and strategies are integrated across all levels of the program.

MOVING HOMELESS SERVICE AND SYSTEMS TOWARD A RECOVERY-ORIENTED APPROACH: LESSONS FROM MENTAL HEALTH AND ADDICTION SERVICES

In 2003, SAMHSA identified eight system-level values that differentiate a recovery-oriented system of care [42]:

- Believing in recovery
- Making "any door the right door" to services
- Using mainstream resources to serve people who are homeless
- Being flexible and/or offering low-demand services
- Tailoring services to meet individual needs
- Developing culturally competent services
- Involving consumers and recovering persons
- Offering long-term follow-up support

It is a challenge to move from recognizing the importance of the recovery concept to creating recovery-oriented programs and moving toward wider systems change. This is further complicated by wide variation in understandings of what constitutes a recovery-orientation.

The following section explores how incorporating individual recovery-oriented values can promote similar changes at the service and system level. We propose that consumer involvement is one concrete step that homeless service programs can take to become more recovery oriented. We discuss the experience of the Connecticut Department of Mental Health and Addiction Services, a pioneer in the development of a recovery-oriented system of care for mental health and addictions treatment. Lastly, we briefly review several instruments used to evaluate recovery orientation in systems of care in the mental health field

RE-THINKING SERVICE DELIVERY

Integrating and implementing recovery-oriented care requires a shift in the traditional service delivery model and organizational culture. Additionally, there must be a fundamental shift in how care is coordinated and responsibilities shared within organizations. Rather than describing people as "sick" or "disabled," recovery-oriented

Table 1. Guiding the Transformation of Service Systems Using Individual Recovery Principles

Traditional Approach	Individual Recovery-Oriented	Service System Recovery
Recovery may not be possible for everyone.	Recovery is possible for all.	Recovery-oriented systems transformation is possible.
Impact of trauma is not well understood in providing services to people who have histories of homelessness.	The impact of trauma plays a central role in the lives of those receiving services.	Policies, practices, and environments are adapted to accommodate the traumatic response in people receiving and providing services.
Tendency to categorize people in a fixed way: "well" or "sick"; "chronically homeless" or "engaged in services" rather than viewing their lives as a dynamic process.	Dynamic and holistic. Views people within the whole context of their lives. Recovery is a process that takes place along a continuum that is not necessarily linear.	Dynamic and holistic. Views the organization itself as organic. Adjusts policies and practices based on consumer and staff input.
Providers are the experts in the recovery process and know what is best for clients. Compliance is expected. Force and coercion may sometimes occur.	Self-determination and autonomy is encouraged with consumers as experts in their own recovery. Agencies are partners in the recovery process. Force and coercion are antithetical to recovery, undermining trust and connection, and leading to retraumatization.	Self-determination and autonomy are encouraged among staff and they are appreciated for their expertise. Focus on decreasing power imbalances and acting in collaborative ways. Policies seek to eliminate coercive practices and reduce retraumatization within the workplace.
Diagnostically driven, symptom-focused.	Strengths-focused, valuing skills and abilities.	Agency strength-focused, values all staff for abilities, skills, and expertise.
Not particularly open to public review.	Information sharing leads to choice, autonomy, greater self-determination, connection, and trust.	Promotes transparency and accountability at all levels by providing information openly.
Relationships are based on hierarchies and positional authority. Power sharing is limited.	Power is shared. Collaborative relationships are based on authenticity, honesty, and recognition of power imbalances.	Collaborative. Values all members of the organization as contributors to the well-being of the agency. Acknowledges power imbalances and seeks to share power when possible.

Source: Prescott L, Harris L. (2007). **Moving Forward, Together: Integrating Consumers as Colleagues in Homeless Service Design, Delivery and Evaluation.** Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Manuscript Submitted for Publication.

care paradigms see individuals as complex human beings with capabilities and strengths as well as struggles and difficulties. Table **1** lays out the shifts required to move from a traditional service delivery approach to a recovery-oriented approach. These shifts emphasize the values of a recovery-orientation for the individual and discuss how these principles and values can be translated into systems of service delivery.

Table **1** contrasts the traditional approach ("recovery may not be possible for everyone") with individual recovery-oriented values ("recovery is possible for all"), and envisions how individual recovery-oriented values can transform service system values, to create a new paradigm of recovery-oriented care and systems transformation ("recovery-oriented systems transformation is possible"). This table is a useful guide for translating individual recovery values for transformation of systems of care.

How can the homeless assistance network begin to integrate recovery principles into systems of care for people experiencing homelessness? One useful starting point is to focus on developing relationships that promote recovery, empowerment, hope, and person-centered values. For a person experiencing homelessness, recovery involves the process of reclaiming one's individuality and status as a human being. Relationships that provide opportunities for individuals to reconnect with supports and function with self-direction, choice, and empowerment can aid the process of regaining personhood. This is especially crucial for individuals who are homeless. Research suggests that individuals who are experiencing homelessness with co-occurring conditions face complex challenges in building healthy social networks [43].

People in recovery from mental health and substance use problems identify having a dependable and reliable person they can trust as both their most significant need and the most significant facilitator of recovery [44]. Many individuals who have moved out of homelessness attribute their success to personal connections with others. Often, the process of rebuilding selfhood happens within the relationship to a service provider. Research suggests that outreach is a critical step toward engaging individuals who are homeless "to establish a personal connection that provides the spark for the journey back to a vital and dignified life" [45]. Reconnecting to a viable sense of self and community is a crucial step in the recovery process for people who have experienced homelessness [46].

CONSUMER INTEGRATION

Consumer integration is one concrete strategy for developing a recovery-orientation in homeless service programs. Integrating people with experiences of homelessness, mental health issues, substance use, and trauma into staff and leadership roles in programs is a necessary step toward transforming organizational culture and service delivery models [7]. Consumer integration promotes the recovery values of empowerment, peer support, and hope and contributes to creating person-centered, recovery-oriented program environments [5].

Programs supporting recovery in mental health and addictions treatment have long embraced the peer support model, moving toward consumer integration in service

design, delivery, and evaluation [5, 47]. Over the past decade, numerous consumer-run and consumer-staffed homeless service programs have begun to emerge [48]. These programs fall into three categories: consumer-run services (managed and operated by a majority of consumers); consumer-partnership services (consumers deliver services in partnership with non-consumers); and consumer volunteers and employees (consumer-staffed) [5].

Consumer integration contributes to a recovery orientation by promoting the empowerment of consumers in all stages of recovery. As "recovery ambassadors," [5] consumer staff members serve as the embodiment of the core recovery principle of hope. As the Projects for Assistance in Transition from Homelessness (PATH) Consumer Involvement Workgroup report notes, "successful integration of consumer practitioners into PATH programs sends an important message to traditional staff and to outside agencies and systems that individuals with serious mental illness who experience homelessness can and do recover, and they can play an important role in the delivery of mental health services to their peers" [49]. A PATH provider in Tucson, Arizona, La Frontera Center is a leader in recovery-oriented peer integration. La Frontera Center works with the Recovery Support Specialist Institute at the University of Arizona to train and certify former consumers as Recovery Support Specialists [5].

In the homelessness field, there is a growing trend toward approaches that support consumer choice, empowerment, and recovery [48]. Housing First [50], Wellness and Recovery Action Plans (WRAP) [51], and Motivational Interviewing [19, 21] are all examples of practices employed by homeless service programs that emphasize consumer choice and recovery.

In a review of consumer integration in the homelessness field, Prescott [5] offers several recommendations and strategies to help programs maximize consumer integration. Prescott's review identifies programs that are leaders in consumer integration and committed to recovery-oriented services. For example, Preferred Behavioral Health of New Jersey, a PATH provider and comprehensive behavioral healthcare provider is dedicated to creating a recovery-oriented agency through implementation of Wellness and Recovery Action Plans (WRAP) and creation of a Wellness and Recovery committee. The organization has been trained in wellness and recovery by the Collaborative Support Program of New Jersey, Inc., a consumer-driven organization [5].

Documentation of the recovery-orientation and effectiveness of consumer-integrated programs tends to be limited to mental health services. For example, SAMHSA's Consumer Operated Service Programs (COSP)'s multisite research initiative evaluated the effectiveness of consumer operated service programs as adjuncts to traditional mental health services. The results demonstrate a strong relationship between recovery-oriented program features and an increase in individual well-being, a construct based on recovery principles [48]. However, while there are descriptive accounts of consumer-run programs for people who are homeless, there is no outcome research on consumer-operated homeless service programs. There is a significant need for research to document how consumer integration can move the homeless assistance forward in the adoption of a recovery-oriented framework of care.

LESSONS IN RECOVERY-ORIENTED CARE FROM CONNECTICUT'S MENTAL HEALTH AND ADDICTION SERVICES

The state of Connecticut has been a leader in the introduction of recovery-oriented care and began its recovery initiative in 2000, before recovery came to the forefront of the national agenda. From the beginning, it was a systemic initiative aimed at transforming the statewide system of care. The Connecticut Department of Mental Health and Addiction Services (DMHAS) was the first state mental health authority to make recovery the overarching goal of its publicly funded system of care [44]. The Connecticut DMHAS defines a recovery-oriented system of care as one that "identifies and builds upon each individual's assets, strengths, and areas of health and competence to support achieving a sense of mastery over his condition while regaining a meaningful, constructive sense of membership in the broader community" [52].

The Connecticut initiative included a collaboration with Yale University's Program for Recovery and Community Health to create a Recovery Education and Training Institute to train providers in areas such as being a recovery guide, person-centered planning, recruiting and working with peer staff, peer support, cultural competency, motivational interviewing, and other topics. In addition, the Connecticut DMHAS solicited applications from agencies to become Centers of Excellence in Recovery-Oriented Practice, which receive free consultations, trainings, and technical assistance from Yale faculty.

It is worth highlighting two lessons from the Connecticut experience. The first lesson learned is that recovery does not refer to any one service, intervention, or support, but rather what people in recovery themselves do to facilitate their own recoveries. This is important because it highlights the importance of involving consumers, being person-centered, and working collaboratively with all stakeholders to develop a shared sense of what a recovery-oriented system of care should look like. The second important lesson from Connecticut's experience is that recovery cannot be simply "added on" to existing services, but must be an overarching goal and value integrated on a systemic level to transform and realign policies, practices, procedures, services, and supports [44]. These lessons provide important precedents that could help inform the adoption of a recovery orientation across the homeless assistance network.

TOOLS FOR MEASURING AND EVALUATING A RECOVERY-ORIENTATION

Systems of care face a challenge of moving from recovery rhetoric to translating recovery principles into standards and objective practices that can be observed and measured. Researchers examining mental health systems of care note that few, if any, systems of care have operationalized the principles of recovery [53]. A significant challenge lies in the complexity of defining recovery and a recovery-orientation. Recovery is both a multi-faceted concept and process, and a review of the literature reveals a wide range of definitions, accompanied by various efforts to

specify and delimit key recovery domains and values [10, 44, 18, 12]. Building on these domains, researchers are beginning to develop methods of measuring recovery and the degree to which care is recovery oriented which can then be operationalized and used to assess and evaluate programs and systems of care [53-56].

In the field of mental health, several instruments have been developed to evaluate recovery orientation in systems of care. The Recovery Measurement Tool was developed as a measure of recovery at the individual level and the Recovery Oriented System Indicators (ROSI) is an indicator designed to determine levels of recovery orientation at the systems level [57]. Another instrument, based on the Schizophrenia Patient Outcomes Research Team (PORT) Client Survey, also offers promise as a tool for assessing a program or intervention's ability to help providers and consumers foster recovery [56]. Other researchers have developed the Recovery Promotion Fidelity Scale (RPFS) to guide on-site fidelity assessments of the incorporation of key recovery practices and principles into the services and operations of community mental health agencies in Hawaii [54].

In 2005, researchers developed and implemented the first statewide assessment of perceptions of recovery-oriented practices. A Recovery Self Assessment (RSA), based on nine basic components of recovery, was administered to directors, providers, and persons in recovery from 78 different mental health and addiction programs in the state of Connecticut to assess perceptions of the degree to which programs had implemented recovery-oriented principles [53]. The findings from this study provided an important baseline assessment of the state of recovery-orientation in Connecticut's mental health and addiction programs.

These instruments and tools for assessment represent important first steps in operationalizing recovery principles into objective practices that will allow for more rigorous evaluation of recovery-oriented practices and programs, outcomes studies, and future program replication. As the homelessness assistance network moves towards integrating a recovery-orientation, it could consider modifying and adapting these tools.

CONCLUSION AND RECOMMENDATIONS

People experiencing homelessness face complex and multi-faceted challenges to recovery. However, recovery from homelessness overlaps significantly with the process of recovery from mental illness, substance use, and/or traumatic stress, especially for individuals with co-occurring conditions. This overlap suggests a significant opportunity for the homeless assistance network to learn from the research, practices, and policies used to promote and implement recovery-oriented care in the areas of mental health, addiction, and trauma care.

Yet, as this paper suggests, it will require a shift in research, practice, and policy for the homeless assistance network to integrate and implement recovery-oriented care. A review of the current literature documents recovery and recovery-oriented interventions in mental health, substance use and addiction, and trauma-informed care, but with little attention to recovery-oriented interventions in homelessness. Many promising practices are currently being employed to promote the recovery of people who are homeless, such as consumer integration, Housing First, Motivational Interviewing, Wellness and Recovery Action Plans, and efforts to integrate a recovery-orientation on Assertive Community Treatment (ACT) teams [58]. Yet a significant gap in both research and practice remains, suggesting various implications for research, practice, and policy around recovery and homelessness.

Additional research is needed to understand the process of recovery for people experiencing homelessness, especially among individuals experiencing co-occurring mental health problems, substance use, and traumatic stress disorders. In addition, research is needed to understand how recovery-oriented care, especially in programs that utilize consumers in a variety of ways, can most effectively serve people who are homeless. While research in mental health care demonstrates improvements in individual outcomes and the quality of services when recovery principles are integrated into practice [10], there is little evidence on how recovery-oriented care impacts outcomes and quality of care in homelessness services. Research should also focus explicitly on the effectiveness of peer integration. Additionally, conducting cost studies could help assess the costs and benefits of specific recovery-oriented practices and services for people who are homeless.

In terms of practice, the homeless assistance network can benefit from the lessons learned from research and practice around recovery in the broader behavioral health fields. One key finding from studies of mental health treatment programs is the importance of consumer integration and peer support for supporting recovery. Homeless service programs can take steps toward recovery-oriented care by committing to a thoughtful process of consumer involvement. Additionally, the tools for operationalizing, assessing, and evaluating recovery and a recovery-orientation developed by researchers in the mental health field could offer useful starting points for the homelessness field. A Recovery Self Assessment (RSA) tool, similar to the one employed to evaluate mental health and addiction agencies funded by the Connecticut Department of Mental Health and Addiction Services, could be employed as a first step to assess the baseline level of recovery orientation of homeless service programs. The RSA is a self-reflective tool that could be adapted for homeless services to begin to identify strengths and weaknesses in recovery-orientation, as well as a promising tool for strengthening feedback loops between providers, consumers, and other stakeholders [53].

Integrating the principles of a recovery-orientation into workforce development initiatives for homeless service providers is another key avenue for practice. Drawing on the successes of Connecticut, states could take a leading role in workforce development by creating Recovery Education and Training Institutes to train providers in providing cutting edge recovery-oriented care. These programs should include training for recovery-oriented peer supports, similar to the Recovery Support Specialist Institute at the University of Arizona [5].

Another important implication for practice is the relationship between recovery-oriented practices and evidence-based practices (EBPs). While some suggest that the recovery movement's emphasis on subjective experience

may be at odds with the EBP movement's emphasis on empirical and experimental evidence, others argue that EBPs can provide an important missing link in the process of integrating a recovery-orientation into systems of care [56]. By integrating measurable recovery principles into new and promising EBPs, providers are given the crucial "how-to" for providing recovery-oriented care. One promising example of a recovery-oriented EBP is Illness Management and Recovery (IMR). IMR helps people to set and work toward personal goals and to implement action strategies for wellness, and is being adapted for use with people who are homeless in different settings.

Finally, the lack of research and evidence around recovery orientation and homeless services suggest the need for coordinated policy at the federal and state level. SAMHSA has indentified recovery as the "single most important goal" for the mental health service delivery system [6], and extending this vision to homeless services would be an important step. At the federal level, work toward aligning recovery paradigms as a step toward defining an overarching recovery vision, similar to that adopted by the state of Connecticut, could provide a platform for collaboration among the diverse federal agencies that fund homeless services.

One promising development at the federal level is the recent creation of the National Center on Homelessness Among Veterans, which is dedicated to promoting recovery-oriented care for veterans who are homeless or at risk of homelessness. By extending this vision to all federally funded programs serving people who are homeless, expectations of recovery-oriented care could be included in program guidance for programs, request for proposals, and evaluations of programs, grants, and contracts.

In conclusion, given the high prevalence of mental illness, substance use, and trauma histories among people who are homeless and the promising outcomes of recovery-based approaches, the adaptation of a recovery-orientation within the homeless assistance network offers significant promise. Given the complex and multi-faceted challenges faced by individuals who are homeless, the recovery principles of empowerment, person-centered values, choice, voice, dignity and respect, and hope are crucial. On a systems level, learning from the lessons of Connecticut's mental health and addictions services, recovery could become an overarching goal and value that could transform and realign the policies, practices, procedures, services, and supports of the homeless assistance network. These changes have the potential of improving the lives of millions of people experiencing homelessness across the United States, allowing them the opportunity to re-build their lives.

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